Patterson v The Queen [2005] NTSC 83

PARTIES:	PATTERSON, John Maxwell
	v
	THE QUEEN
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	APPLICATION FOR A PERMANENT STAY OF CRIMINAL PROCEEDINGS
FILE NO:	20508217
DELIVERED:	22 December 2005
HEARING DATES:	16 December 2005
JUDGMENT OF:	OLSSON AJ

CATCHWORDS:

Criminal jurisdiction - Application for permanent stay of trial on "common humanity" grounds - Accused charged with five sexual offences in relation young female child in 1995 - Suffers from multiple serious medical conditions - Accused in palliative care with life expectancy in terms of months rather than years - Evidence of likely deleterious effect of trial on existing medical conditions - Discussion of principles related to stay applications - Common humanity test satisfied - Stay granted.

REPRESENTATION:

Counsel:

Appellant:	R Goldflam
Respondent:	N Rogers

Solicitors:

Appellant:	Northern Territory Legal Aid Commission
Respondent:	Office of the Director of Public Prosecutions

Judgment category classification:	B
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT ALICE SPRINGS

Patterson v The Queen [2005] NTSC 83
20508217

BETWEEN:

PATTERSON, John Maxwell
Appellant

AND:

THE QUEEN
Respondent

CORAM: OLSSON AJ

REASONS FOR JUDGMENT

(Delivered 22 December 2005)

INTRODUCTION

[1] This is an application by John Maxwell Patterson for an order granting a permanent stay of criminal proceedings brought against him.

[2] Following relevant committal proceedings, he is to be presented for trial before a jury at the criminal sittings to be held in Alice Springs in February 2006. Six half days have been assigned in the list for that purpose, on 8, 9, 10, 13, 14 and 15 February 2006. I infer that this unusual course was taken having regard to his known medical condition.

[3] An indictment dated 17 November 2005 filed by the Director of Public Prosecutions charges the accused with five separate accounts of having sexual intercourse with a young female child at Tennant Creek (to whom I

shall refer as *"the alleged victim"*) without her consent between 1 January 1995 and 31 December 1995.

[4] The alleged victim is a young female now about 15 years of age. It is said that the conduct asserted against the accused occurred when she was only about five years of age, but has only recently been the subject of complaint by her. I am informed that the accused and the alleged victim and her family were neighbours at Tennant Creek.

[5] The application was heard by me sitting at Alice Springs. The accused is normally resident in Tennant Creek. Due to the state of his health, he participated in the hearing by Video link from Tennant Creek Courthouse.

THE EVIDENTIARY BASE OF THE APPLICATION

[6] The accused is a man now about 65 years of age. His presence by Video link was accompanied by almost constant loud wheezing sounds and/or coughs that I take to be associated with his breathing difficulties. These were, on the medical evidence before me, part and parcel of his normal physical presentation. He was seated in a wheelchair and accompanied by one or more attendants for the whole of the time. He appeared to be of quite obese build.

[7] Mr Goldflam, of counsel for the accused, called Dr Joanne McKeown, a palliative care consultant employed by the Central Australia Palliative Care Service, to give oral evidence in support of the application. She is a Fellow of the Australasian Chapter of Palliative Medicine (a chapter of the Royal Australasian College of Physicians). Her medical expertise in her specialty was not challenged.

[8] Dr McKeown testified that she has had the general oversight of the accused's treatment since June last, although he has (and has had) other specialist medical advice for specific aspects of his conditions. She gave

evidence to the effect that the Central Australia Palliative Care team had been treating the accused since April of this year.

[9] She said that the team takes care of people with life limiting illness and usually that illness is going to be life limiting in terms of months and not years. She went on to testify that, in the case of the accused, it was felt that the level of symptoms that he had relating to his illness and his likely short life expectancy were such that the team would aim to improve his quality of life by addressing some of the symptom related issues.

[10] Dr McKeown's evidence was to the effect that the accused suffers from no less than 14 separate medical problems, namely :

(1) *Severe bilateral bullous emplysema:*

This was first diagnosed in 1995 and has steadily become progressively worse over time. It causes shortness of breath even at rest, recurrent respiratory infections, episodic chest tightness and wheeze. He has a chronic cough. His condition has now deteriorated to the point whereby he is reliant on continuous home oxygen to alleviate his shortness of breath. He must ingest a constellation of medications referred to by Dr McKeown in a written report prepared by her. He is virtually immobile, except in a wheelchair.

The doctor gave evidence to the effect that, between March and December of this year, he has been admitted to hospital in Tennant Creek on eight occasions, for periods varying from one day up to two weeks. He is prone to recurrent bouts of pneumonia. He has also had to present to the Emergency Department of the hospital on a number of occasions.

(In the course of her oral evidence Dr McKeown commented that it is likely that the accused's respiratory condition will gradually deteriorate. She said that it had certainly noticeably deteriorated in the last six months and it was her opinion that he will have further and more frequent admissions to hospital in the immediate future).

(2) *Asthma:*

This is a condition that exists in parallel with the emphysema and requires specific treatment of its symptoms.

(3) *Sleep apnoea:*

This is additional to the diagnosis of emphysema and was diagnosed in 2000. It contributes tot the symptoms associated with the latter condition.

(4) *Osteoporosis:*

This is secondary to the prolonged steroid medication that has to be administered for the emphysema.

(5) *Glucose intolerance/non-insulin-dependent diabetes:*

This is also secondary to the treatments for the emphysema.

(6) *Gastroesophageal reflux:*

This is also secondary to that treatment and the accused's obesity.

(7) *Obesity:*

This is secondary to his steroid treatment and his virtual immobility, due to respiratory comprise. He currently weights 117kg.

(8) *Degenarative disc disease of the lumbar spine with chronic pain:*

In about 1961 the accused injured his back in a high-speed boat accident. This required surgery with initial good results. In 1999 he developed a recurrence of low back pain, with burning left leg pain and altered sensation consistent with spinal canal stenosis. X-rays disclosed severe degeneration at the L5/S1 level and this was confirmed by an MRI scan. Unfortunately, the accused's severe emphysema rendered remedial surgery impractical.

In the result, the accused has experienced increasing back and bilateral lower limb pain and was therefore commenced on morphine in December 2002. He requires regular morphine to alleviate his pain and the dose of morphine has been increased in the last few months, as his pain has worsened.

(9) *Cardiovascular problems:*

The accused has a history of hypertension and high cholesterol level and is currently taking medication for management of mild cardiac failure.

(10) *Rectal bleeding*

In 2000 the accused was found, on colonoscopy, to have multiple non-malignant polyps and haemorrhoids. It has not proved possible to follow this up in more recent times because the accused's emphysema renders the relevant procedures too risky.

(11) *Left rotator cuff injury:*

The accused sustained an injury to his left shoulder in May 2002. Due to his other conditions it has not proved possible to do other than attempt pain relief for this condition.

(12) *Chronic chest wall pain:*

The aetiology of this pain is unclear but is thought to be musculoskeletal in origin.

(13) *Anxiety/depression:*

Is said that the accused's health conditions have severely limited his ability to take part in normal day-to-day activities and that he has, in any event, been under a significant level of stress. Whilst, no doubt, some of the stress, in more recent times, has been due to the bringing of criminal charges against the accused, the fact remains that the diagnoses of anxiety/depression were made as long ago as June 2003. Dr McKeown reported that anxiety is a common symptom in patients with respiratory disorders, because those patients often have an overwhelming sensation of inability to catch their breath and, at times, complain of a suffocating sensation. Depression can also be a side effect of the steroid treatment administered to the accused.

(14) *Swallowing Difficulties:*

This accused has exhibited problems with dysphasia for many months, although the aetiology of the problem is unclear at this time.

[11] In her written report dated 26 October 2005 Dr McKeown made these specific points:

- At that time the accused was physically capable of travelling from Tennant Creek to Alice Springs, although his actual medical condition at some future time such as the dates fixed for the trial in 2006 is unpredictable and he could exhibit acute symptoms disabling him from so doing at any time;

- Equally, he could, at the date, physically attend his trial providing that there was wheelchair access to the court, he had appropriate seating to cater for his back pain, a continuous oxygen supply, and the opportunity to take a break if he needed nebulised medications such as Ventolin. Once again, his situation in 2006 is unpredictable and he could suffer disabling symptoms at any time; and

- A trial might very well exacerbate his medical conditions and in particular his anxiety and depression. It would certainly be unlikely that he could complete full days in court. His level of respiratory compromise is severe and he uses a significant amount of energy just to breathe.

[12] In her report Dr McKeown further commented that *"His conditions are complex, progressive and interrelated in ways that make them very difficult to manage even in an acute care setting. At present he relies on the full time care of his partner at home just to manage activities of daily living. He needs frequent medical review and often has sudden deteriorations in his health necessitating urgent hospital admission. Unless a full-time carer, continuous oxygen and ready access to hospital care were available it is likely that Mr Patterson's health would deteriorate very quickly.* ***His condition is very unstable, unpredictable and progressively deteriorating, prognosis is poor (months more likely than years)"*** *[The emphasis is mine].*

[13] In the course of her oral evidence Dr McKeown said that, with time, the accused is becoming less and less able to take part in activities and that infections that come as a result of his emphysema can, at any time, lead to a rapid deterioration of his health. Although the emphysema is slowly progressive, any infection could be one that progresses to respiratory arrest and ultimately lead to death.

[14] She made the point that to come into court will be a stressful experience physically and intellectually for the accused and that it is more than likely that he would experience an exacerbation of his condition. She said that

he is not accustomed to getting dressed and leaving the house every day. Sometimes he is still in bed at lunchtime.

[15] The following exchanges occurred between Mr Goldflam and this witness:

"MR GOLDFLAM: And if he does suffer an exacerbation in a trial, in your opinion, what is the risk that that exacerbation could be grave? -

I think any infection that he developed - any exacerbation of his airways disease at any time could be quite grave and up until now, fortunately, the infections he's developed have been treatable. There's no guarantee that that will continue to be the case and generally patients with this problem tend to develop more and more resistant infections as time goes on. So, it's quite possible that that could be something that limited his life, definitely. You have indicated or you've provided the opinion in your report that the trial is most likely if it is going to exacerbate the condition it would particularly exacerbate anxiety and depression. How, if at all, is that linked to his primary dangerous condition - the emphysema? - Yep. I think those two conditions are strongly linked, in that patients with airways disease often have problems with anxiety and we know that anxiety and adrenaline and use of energy prevents people from having enough energy, effectively, to breathe. He uses almost all his energy breathing and then any energy that is taken up by anxiety and adrenaline surge that people get with that is likely to make it more difficult for him the breathe. We know that stress, in particular, suppresses people's immune systems and I suspect that's what happens when he becomes distressed then gets respiratory infections because his immune system was suppressed then."

[16] In cross-examination this witness expressed the opinion that the accused would have difficulty sitting through six half days of trial. As to this she commented:

"No, I think that any activity where he would need to be a certain place at a certain time for a certain period of time is going to be very difficult in view of his respiratory compromise. It takes him a lot of time just to get dressed, to get up in the morning, to have a shower. All of those things use up so much energy before even getting where he needs to go, that my understanding is that his trips outside the house, at the momen, are limited to really going to the hospital or to the GP. So, I'll be surprised that he could do six half days."

[17] Dr McKeown said that, on the last occasion on which her service visited the accused in November, he was still in bed at lunchtime, quite breathless and even sitting up out of bed was quite difficult for him.

RELEVANT PRINCIPLES

[18] In the course of my judgment in *R v Burns (No 2)* (1999) 169 ALR 149, I pointed out that there can be no doubt that, at common law, a judge, exercising the inherent power of the Court, has a discretion to stay criminal proceeding where, by virtue of any situation, it would be unacceptably oppressive and unfair to an accuse to permit the trial to proceed (R v Gagliardi and Filippidis (1987) 45 SASR 418 at 433).

[19] If a stage is reached whereby, for example, the state of health of an accused is such that the person concerned is not fit to do justice to himself as a witness or undergo a substantial cross-examination then a proposed trial ought not to be permitted to proceed *(cf R v Howson (1982) 74 Crim App R 172).*

[20] The *locus classicus* on this general topic is the well-known decision of the Court of Appeal in *Hakim (1989) 41 A Crim R 372 at 376-377.* Kirby P (as he then was) emphasised the initial point that the jurisdiction was an exceptional one, to be used sparingly. He accepted the

proposition that, whilst it will be a rare case in which intervening illness or the physical or mental condition of an accused will warrant a stay, nevertheless, if the Court concludes, on the evidence before it, that it would offend common humanity to require an accused to stand trial, a stay would be justified.

[21] In the case of *Subramaniam v The Queen (2004) 79 ALJR 116 at 123* the High Court cited *Hakim* with approval. The joint judgment in *Subramaniam* reiterated that, on an application such as that now before me, it is the task of the judge to embark upon -

"a weighing process involving a subjective balancing of a variety of factors and considerations. Among those factors and considerations are the requirements of fairness to the accused, the legitimate public interest in the disposition of charges of serious offences and in the conviction of those guilty of crime, and the need to maintain public confidence in the administration of justice".

[Walton (1993) 177 CLR 378 at 396]

[22] Some further assistance can be gleaned from the decision of the Court of Criminal Appeal in *R v Westley [2004] NSWCCA 192*. Dunford J, having referred to the cases of *Austin* and *Littler* in which a combination of factors such as the age of the accused, the state of his health, and the impact of delay had warranted a stay, stressed that it would not be enough for the evidence to indicate that the stress of a trial *might* cause an accused's condition to deteriorate. The evidence needed to indicate that this *would or probably would*, do so and that the likely consequence would be serious.

THE PRINCIPLES APPLIED

[23] In the course of her submissions, Dr Rogers emphasised the serious nature of the charges against the accused and the public interest in bringing them before a jury for disposition. Those are, undoubtedly, important considerations, not least because the charges involve allegations of serious sexual offences against a young female child. True it is that the allegations concern events said to have occurred some 10 years ago, but that is far from the unusual in relation to matters of this type in which a young person articulates a narrative of events only after attaining sufficient maturity to be able to face up to doing so.

[24] Having made those points, it must be said that Dr Rogers did not seek to join issue with the accuracy of the evidence and the opinions proffered by Dr McKeown. Rather, she pointed to the fact that this witness was prepared to concede that it would be *physically* possible for the accused to be brought to Alice Springs for a trial; and that special arrangements had already been put in place to conduct the proposed trial in six, sequential half day sittings, rather than as what would otherwise be a normal three-day, continuous trial.

[25] Those aspects must be conceded as accurate reflection of the situation.

[26] However, it seems to me that, with respect, Dr Rogers' submissions necessarily fall far short of meeting the real gravamen of the accused's case on the present application.

[27] There can be no question but that this 65 year old man is in a terminal medical condition. One need do no more than observe his presentation on Video link to recognise the parlous condition of his health. He constantly wheezes and coughs in a loud, apparently involuntary, manner that would,

in fact, cause an attempt at an orderly conduct of a trial to be something of a nightmare.

[28] More importantly, the uncontroverted evidence is to the fact that his life expectancy is to be measured in months rather than years; it is most unlikely that he would be able to present for trial on a continuous daily basis, even for half day sessions; and that requiring him to undergo a trial will be a stressful experience *"more than likely"* to exacerbate his physical problems.

[29] I take the doctor's evidence to indicate that there is a high degree of likelihood that the anxiety and adrenaline surge involved in participating in a trial would suppress the accused's immune system to the point that it might well trigger off a further respiratory infection that could even be fatal.

[30] I have no hesitation in concluding that this is one of those rare cases in which it would offence common humanity to require the accused to stand trial in the circumstances. This is so even if it was, strictly speaking feasible to conduct an orderly and satisfactory trial of the charges. Indeed, I seriously question whether that is practicable, having regards to Dr McKeown's evidence, considered against my own observations of the accused.

[31] Accordingly, I order that the proceedings on the indictment dated 17 November 2005 against the accused by permanently stayed.

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